

October 3, 2002

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-02-1154-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed MD specialized and boarded in Neurological Surgery and Pain Management. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ suffered a work-related injury on ___. In 1998 she subsequently underwent a fusion at L4-L5. She was suffering with chronic low back pain and when seen by ___ on 6/27/02 she related to him that three weeks prior to that date her legs had given way and she fell with a subsequent increase in her pain. ___ requested a CT scan of the lumbar-sacral spine as she had not had neuroradiographic imaging studies in a year. The patient was noted by ___ to be a "chronic pain patient" and that this had really not changed subsequent to the ___ surgery. The persistence of a chronic lumbo-sacral spine syndrome essentially denotes this patient as having a failed back surgery syndrome. X-rays of the lumbo-sacral spine dated 8/15/02 were reported as showing a fusion that was likely solid with no movement seen on flexion and extension. As well, bone was seen growing behind the cages placed during the posterior lumbar interbody fusion at the level of L4 and L5, and the spine was well aligned.

REQUESTED SERVICE

Lumbar CT scan

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

Within a reasonable degree of medical certainty, and based upon care standards, I believe that based on records of multiple follow-up visits with her treating physicians (which were included for my review) the patient appears to have reached maximal medical improvement from her ___ surgery. The surgery was causally related to her ___ work-related injury, and ___ has simply been maintained subsequent to that surgery as a chronic pain patient. Follow-up neuroradiographic images as outlined above showed more than adequate healing of the 1998 L4-5 posterior lumbar interbody fusion. I therefore believe that she sustained a new injury three weeks prior to her June 2002 office visit. The new injury is a result of her fall, which is unrelated to her prior treatment.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TDI/TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).